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CHILD/ADOLESCENT INTAKE FORM

Child's Name: _____ **Date of Birth:** _____

Address: _____ **Age**: _____

City: _____ **State:** _____ **Zip:** _____ **Sex:** _____

School: _____ **Grade:** _____

Custody of Child (e.g., physical and/or legal): _____

Father/Guardian

Name: _____

Date of Birth: _____

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

May a message by left on: ☐ **Home Phone** ☐ **Cell Phone**

Parent e-mail: _____

Mother/Guardian

Name: _____

Date of Birth: _____

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

May a message by left on: ☐ **Home Phone** ☐ **Cell Phone**

Teacher e-mail: _____

Primary Care Physician: _____

I hereby give my permission for my child to receive services.

_____ _____

Signature of Legal Guardian **Date**

Child's Name _____

Reason for referral:

_____

_____

_____

_____

_____

Were there any complications with the pregnancy, labor, or delivery? Please explain.

_____

_____

_____

Gestational Age: _____ **Birth Weight:** _____

At what age were motor milestones (sitting, standing, walking) and speech/language milestones (first words, two word phrases, sentences) met?

_____

_____

Who lives in the home with your child?

_____

_____

Describe the parenting style(s) within the home.

_____

_____

Has the child experienced any abuse?

Was the child exposed to any drugs, alcohol, or prescription medicines during his/her mother's pregnancy?

Does the child have an IEP (individualized education program) in school? If yes, please explain the reason he/she is receiving individualized education.

Does the child have any current medical/mental health diagnosis(es)? If so, please list them and provide the age at which they received such diagnosis(es), even if you may have already mentioned them elsewhere on this form.

Describe the parent/child relationship.

_____

_____

Siblings (ages & medical/mental health diagnoses)

_____

_____

Describe your child's relationship with his/her siblings.

_____

_____

Describe your child's relationship with adults and peers.

_____

_____

Sleeping habits:

_____

Eating habits:

_____

Describe any past/current family stressors or traumatic events.

_____

_____

_____

Previous therapy, evaluations, and mediation (prescribing physician):

_____

_____

Current therapy, evaluation, and medication (prescribing physician):

_____

_____

Is there any additional information you wish to share?

_____

_____

_____

_____

_____

PRIMARY INSURANCE/FINANCIAL INFORMATION

Name of Primary Insurance: _____

Policyholder's Full Name: _____

Policyholder's Date of Birth: _____ **Policyholder's Social Security Number:** _____

Policyholder's Employer: _____

Group Number: _____ **Policy/ID Number:** _____

Insurance Telephone #: _____

Do we have your permission to communicate with the person/organization referring you/your child?
☐ **Yes** ☐ **No**

Client's or authorized signature. I authorize both the release of any medical information necessary to process my claim and authorize payment of medical benefits to The Psychology Clinic and/or the providing therapist.

_____ _____

Signature of Legal Guardian **Date**

Secondary Insurance: _____

Policyholder's Full Name: _____

Policyholder's Date of Birth: _____ **Policyholder's Social Security Number:** _____

Policyholder's Employer: _____

Group Number: _____ **Policy/ID Number:** _____

Insurance Telephone #: _____

Client's or authorized signature. I authorize both the release of any medical information necessary to process my claim and authorize payment of medical benefits to The Psychology Clinic and/or the providing therapist.

_____ _____

Signature of Legal Guardian **Date**

POLICIES & PROCEDURES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session.

CONFIDENTIALITY

All communications between client and therapist will be held in confidence, and will not be revealed to anyone unless you (or parent, in the case of a minor) give written authorization to release this information. Your legal right to privileged communication between a licensed psychologist and a client will be upheld unless overruled in a court of law during a legal proceeding. Georgia law requires that confidentiality be waived when the client's or other's personal safety is threatened or when disclosure of child abuse is made to the therapist. If we determine that a client presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

MINORS AND PARENTS

Unemancipated clients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child or be countertherapeutic. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any of his/her objections.

FINANCIAL ARRANGEMENTS AND INSURANCE

Initial consultation**,** 45-55 minute individual and/or family sessions, and psychological assessments and interpretations are billed at $200.00 per clinical hour. It is your responsibility to pay your bill. Our office will be glad to file your primary and secondary insurance for you (please provide our office with a copy of your insurance card). We cannot file tertiary insurance. I**f your insurance company is unwilling to pay, it is your responsibility to make payment and contact the insurance company.**

LATE CANCELLATIONS/MISSED APPOINTMENTS

We reserve a therapeutic hour for each person(s) scheduling an appointment; and our income is based entirely on the hours we see clients. If someone cancels late or misses an appointment, we incur a loss of income for that hour and are not able to offer that time to someone who may be waiting, possibly in crisis. Therefore, we must have an agreement that the appointment will be kept or, if you must cancel, we need to have ample notice to prevent this type of loss. Regardless of cause, The Psychology Clinic requires a 48-hour notice on cancellation to release you from your responsibility for that time scheduled. **You will be billed for late cancellation and/or missed appointments at a rate of $75.00 per clinical hour.** Please note that insurance companies do not reimburse for canceled or missed sessions.

I/we agree to the above terms of the late cancellation/missed appointment policy of The Psychology Clinic and will make prompt payment on any charge I/we incur for a late cancellation or missed appointment. I understand the therapeutic and economic necessity of such a policy. Your signature below indicates that you have read and understand the policies and procedures described above.

_____ _____

Signature of Legal Guardian **Date**

NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HELATH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider such as your family physician or another psychologist.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to actives outside our [office, clinic, practice] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or heath care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given more protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided that each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Law provides the insurer the right to contest the claim.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances.

Child Abuse-if we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority.

Adult and Domestic Abuse- If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authorities.

Health Oversight Activities- If we are the subjects of inquiry by the Georgia Board of Psychological Examiners, we may be required to disclose protected health information regarding you in proceedings before the Board.

Serious Threat to Health or Safety- If we determine, or pursuant to the standards of our profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

I have read the above and understand that it is my responsibility to make sure all insurance requirements are fulfilled. It is also my responsibility to notify this office of any changes in my insurance. I agree to be responsible for all charges incurred with The Psychology Clinic that result from non-covered services or client's failure to meet insurance requirements.

_____ _____

Signature of Legal Guardian **Date**